STATEMENT OF THE
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BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

HEARING ON THE DEPARTMENT OF VETERANS AFFAIRS
MEDICAL CARE COLLECTION FUND

September 20, 2001

Mr. Chairman and Members of the Subcommittee, I am here today to report on our work concerning the Department of Veterans Affairs (VA) Medical Care Collection Fund (MCCF). During the past several years, the Office of Inspector General (OIG) has reviewed selected VA MCCF issues and has identified opportunities to enhance MCCF recoveries.

Background

In accordance with Title 38, U.S.C. 1710, 1712, 1722A, and 1729, VA collects reimbursements from third-party health insurers and certain veterans to offset the cost of medical care and medications for treatment of nonservice-connected conditions.

The Balanced Budget Act of 1997 (Public Law 105-33) authorized VA to establish the MCCF, which replaced the Medical Care Cost Recovery (MCCR) program. VA now retains all MCCF collections to be utilized to provide additional health care resources for our nation's veterans.

Public Law 105-33 also authorized VA to bill "reasonable charges" for medical care provided on or after September 1, 1999. Reasonable charges are defined as amounts that insurers would pay private sector health care providers in the same geographic area for the same services. Billing reasonable charges is more labor intensive and time consuming than billing cost based per diems, but it results in higher recoveries.

The effectiveness of billing reasonable charges relies upon accurate documentation of the medical care provided, use of consistent business processes, and compliance with policies and procedures. Billing and collection is

the end of a process that includes determination of eligibility and entitlement when a patient checks in, verification of the patient's insurance coverage, coordination of care with an insurance carrier, complete and accurate documentation of treatment in the patient's medical record, and accurate coding of the diagnosis and/or medical procedures provided using industry standard codes, such as the International Classification of Disease (ICD-9) and Current Procedural Terminology (CPT-4) systems. All these processes must work together to produce timely and accurate bills, and ultimately collections.

VHA expected that the authority to bill for reasonable charges and the ability to retain MCCF revenues would motivate managers to increase collection efforts. VHA established minimum annual MCCF collection goals for its Veterans Integrated Service Networks (VISNs) and member medical facilities to further encourage MCCF efforts. As shown below, between Fiscal Years (FYs) 1998 and 2000 collections were essentially flat, and VHA did not achieve its collection goals, even after lowering the FY 2000 collection goal 10 percent below the FY 1999 goal. However, collections have increased significantly through the first 10 months of FY 2001 and are on pace to exceed $750 million for the year. According to MCCF program managers, the increased collection rate is due in large part to implementation of the higher billing rates under reasonable charges.

Fiscal Year	Goal (Millions)	Collections (Millions)
1997	$544	$520
1998	$634	$560
1999	$671	$574
2000	$605	$573
2001	$605	$632 (through 07/31/01)

Previous Audit Effort

On July 10, 1998, we issued "Audit of the Medical Care Cost Recovery Program, Report No. 8R1-G01-118." (www.va.gov/oig/53/reports/98-2reports.htm) We determined that VHA could increase MCCR recoveries by over $83 million by requiring VHA facilities to (1) use management tools, such as preregistration software, to identify and bill insurance carriers more timely, (2) more aggressively pursue collection of accounts receivable, (3) establish and monitor performance standards for MCCR staff, and (4) demonstrate how MCCR recoveries benefited veterans.

VHA concurred with our findings, recommendations and estimated benefits. The VHA action plan included VISN-based training sessions and tasking for procedural changes to implement OIG recommendations. VISN Directors were also required to establish appropriate performance standards. VHA held meetings with Veterans' Services Officers and distributed informational brochures describing third-party billing and the circumstances under which veterans would

make co-payments. Additionally, veterans were informed that MCCR collections would be returned to benefit veterans in the region where the revenues were derived.

Combined Assessment Program Reviews

Our Combined Assessment Program **(**CAP) reviews provide an independent and objective assessment of key operations and programs at VA medical facilities on a cyclical basis. CAP reviews completed at VA medical facilities since March 31, 1999 have identified the following MCCF program weaknesses:

- Facility staffs were not effectively determining veterans' eligibility and entitlement status.
- Facility staffs were not effectively verifying and coordinating patient care with insurance carriers.
- Medical record documentation of care provided was not adequate.
- Bills to insurance carriers were not accurately coded.
- Bills to insurance carriers were not issued in a timely manner.
- Collection efforts on delinquent accounts were not aggressively pursued with insurance carriers.

For example, a recent CAP review disclosed 70,205 backlogged third-party reimbursement claims valued at about $10.5 million. In addition, the time required to prepare a bill following delivery of outpatient care averaged about 241 days. Studies have shown that shorter billing lag time improves recovery rates. The Facility Director estimated that the VAMC could increase MCCF recoveries by about $3.2 million by processing outpatient bills that are currently backlogged.

In response to each of the MCCF weaknesses identified, facility management agreed to take the necessary corrective actions that we recommended.

Current Healthcare Inspection Effort

The OIG, Office of Healthcare Inspections (OHI) is evaluating the effectiveness of VHA's efforts to improve the accuracy of coding medical services provided to veterans.

We reviewed outpatient coding accuracy, data reliability, training initiatives, and implementation of compliance programs at 15 VA medical facilities visited during Fiscal Year (FY) 2001. Our review showed that employees need to focus their attention on reducing the coding error rate for outpatient visits, and improving

their internal control processes. About 50 percent of the 570 outpatient visits reviewed contained coding errors, which was significantly higher than the 30-percent error rate Health Care Finance Administration (HCFA) reported from its review of private sector billings in 1996.

During FY 2000, VHA recovered about $155 million from third-party billings pertaining to outpatient services.

We found that medical record documentation did not consistently support the codes assigned, which resulted in the VA overcharging or undercharging for services rendered. For the billable visits reviewed, the error rate was 43 percent. Of these visits, 67 percent were up-coded, while 33 percent were down-coded. Third-party payers had reimbursed some of these bills at the incorrect rate, and managers told us that they would contact the insurance companies involved and make the necessary adjustments. The 43 percent error rate is unacceptable and represents a significant risk. We found a number of billable visits in which bills had been cancelled because of inadequate documentation or lack of attending physician documentation. While canceling these bills was appropriate to avoid inaccurate billing, revenue was lost due to poor documentation.

We concluded that VHA managers need to set incremental goals to improve outpatient coding accuracy, data accuracy, and training for clinicians and coders.

Current Audit Effort

We are currently conducting an audit of FYs 2000 and 2001 MCCF billings and collections. We are assessing MCCF policies, procedures, and operations to (1) determine the accuracy and timeliness of MCCF third-party billing for inpatient care, (2) evaluate the effectiveness of MCCF accounts receivable management, and (3) follow-up on the implementation of recommendations made in our 1998 audit report.

Although collections are increasing in FY 2001, interim audit results show potential for significant additional collections. Conditions identified in our 1998 report, including missed billing opportunities, billing backlogs, accounts receivable management, and procedures to identify and verify patient insurance coverage, still need improvement. The following are some of the problems we have identified to date.

Billing Backlogs

Timeliness of billing affects the amount collected. We reviewed the days elapsed from the date of care to the date of billing for billings randomly sampled from 3,918,136 bills issued during the period October 1,1999 to September 30, 2000. On average, 95 days elapsed (84 days average for inpatient bills and 108 days average for outpatient bills). By contrast, our 1998 audit found a 48-day average

to bill for services and, in calendar year 2000, private industry averaged only 10 days to issue bills.

VHA's Unbilled Care Report, cumulative as of July 2001, showed that $931 million had not been billed ($254 million for inpatient care, $660 million for outpatient care, and $17 million for prescriptions). We estimate that based on VHA's current collection rate (approximately 34 percent of the amount billed), issuing the bills comprising this backlog could result in additional collections of approximately $317 million.

Missed Billing Opportunities

Our review of randomly sampled cases from 739,634 FY 2000 patient discharges identified a number of cases that should have been billed. These missed billing opportunities occurred primarily because the treatment provided by attending physicians was not adequately documented in the medical record to establish the bill of collection. Based on the sample results, we estimate that VHA missed the opportunity to recover $18 million for inpatient care provided to 47,000 veterans during FY 2000.

Accounts Receivable Management

We also reviewed third-party inpatient treatment bills randomly sampled from a universe of 234,464 FY 2000 bills valued at approximately $1.37 billion. We found that VHA staff did not follow-up with insurance carriers on delinquent receivables as required by VA policy in 77 percent of the cases reviewed. Collections increase when staff follow-up on delinquent receivables. We estimate that VHA lost the opportunity to collect $117 million by not following-up with insurance carriers.

Insurance Identification

Questionnaire responses received by us from 135 VHA facilities indicated that 24 facilities (18 percent) were not using preregistration software as required by VHA. The software helps identify insurance coverage and collect information before the veteran comes to the facility for treatment. We recommended that VHA use this software to improve identification of patients with health insurance in our 1998 audit report. VHA program officials told us that veterans are more willing to provide health insurance information through this process.

Implementation of 1998 Audit Recommendations

We also found that other recommendations made in our 1998 report were not effectively implemented. VHA had not established performance standards for clinical and administrative staff conducting patient registration, coding, billing, collection, and utilization review. Further, VHA still needs to better educate

veterans about the importance of MCCF collections to the medical facility and to dispel any misconceptions veterans might have regarding loss of insurance coverage or increased premiums upon disclosing insurance information to VA.

Based on our current audit to date, we believe the Under Secretary for Health would further improve MCCF activities by:

1. Directing that VISN and VA medical facility Directors ensure that billing opportunities are not missed, the backlog of bills is eliminated, and future bills are issued timely.

2. Communicating MCCF performance goals/expectations to VISN Directors and medical center directors and holding them accountable for results by measuring their performance and addressing performance gaps.

3. Establishing performance standards for clinical and administrative staff involved in all phases of the MCCF (patient registration, coding, billing, collection, and utilization review) and requiring VISN and VA medical facility Directors to monitor performance results and take action to improve performance.

4. Expanding training for personnel involved in the billing process (patient registration staff, physicians, coders, billers, collection staff, and utilization review staff).

5. Ensuring that VA medical facilities use the preregistration software as required.

6. Following up with insurance carriers on delinquent receivables, as required by current policy.

7. Continuing to promote the importance of the MCCF program to veteran patients and staff by demonstrating how MCCF collections benefit each facility's ability to provide medical services to veterans.

By effectively implementing our previous recommendations, we believe VHA could have increased collections by $135 million in FY 2000. By clearing the backlog of $931 million in Unbilled Care, VHA could increase current collections by an additional $317 million.

This concludes my testimony. I would be pleased to answer any questions that you and the members of the subcommittee may have.